



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Environment of Care,
Infection Control Practices,
Provider Availability, and
Leadership

VA Loma Linda Healthcare
System

California



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Congressmen Pete Aguilar and Mark Takano to review concerns related to environment of care (EOC), infection control practices, provider availability, and leadership responsiveness at the VA Loma Linda Healthcare System (facility), California.

Based on the information received from congressional staffers, OIG leaders identified the following group of issues to review:

- EOC including availability of bedpans and urinals
- Infection control practices
 - *Legionella* infection and water testing
 - Clostridium difficile (*C. difficile*) infections¹
 - Sterile Processing Services (SPS) controls (temperature and humidity, biological spore testing, and air change and pressure)
 - Bloodborne pathogens training
 - Performance data related to infection control practices
- Leadership responsiveness to EOC concerns
- Hospitalists and nocturnists availability
- Mental Health Service staffing, access, and performance data

In addition, the OIG received allegations that inpatient dental clinic patients and staff were exposed to biohazard residue, and Environmental Management Service (EMS) staff did not routinely clean this area.²

On March 12, 2018, the OIG conducted an unannounced inspection of the main hospital building. In general, the facility's EOC was not clean and furnishings needed repair.³ The next day the OIG inspected the Ambulatory Care Center and identified three EOC cleanliness concerns. While inspecting inpatient units, OIG staff found a readily available supply of bedpans and urinals.

During the EMS managers' interviews, the OIG identified potential factors that may have contributed to the lack of cleanliness at the facility. The factors included a lack of consistent

¹ *C. difficile* is a spore-forming bacterium that can readily survive on surfaces for extended periods of time. Infection can be spread by touching contaminated surfaces and ingesting spores. *C. difficile* spores are difficult to eliminate and are not destroyed by alcohol-based hand sanitizers. <https://www.niaid.nih.gov/research/clostridium-difficile>. (The website was accessed on January 8, 2019.)

² The inpatient dental clinic is an area designated to provide dental care to inpatients.

³ Facility leaders observed EOC findings with the OIG team.

EMS leadership; lack of facility-wide policies regarding cleanliness, standard sanitation practices, and EMS standard operating procedures; and a failure to adhere to EMS processes for evaluating the level of competence and tracking education and training of EMS housekeeping staff.

An OIG medical consultant reviewed *Legionella* urinary antigen tests performed at the facility from October 2015 through September 2017 and determined the two patients with positive tests did not acquire *Legionella* at the facility. To further evaluate facility *Legionella* testing, the OIG reviewed the electronic health records of 22 patients who had pneumonia as a primary or secondary cause of death and no *Legionella* testing. The OIG determined that the *Legionella* urinary antigen test was not indicated in the 22 patients. Although the OIG did not find a specific instance of inappropriate *Legionella* testing, the OIG found that facility leaders did not have a standardized process for notifying clinical staff of *Legionella* water testing results.

OIG staff reviewed *Legionella* water testing results for buildings and areas subjected to Veterans Health Administration (VHA) Directive 1061.⁴ The facility leaders' actions for positive *Legionella* water tests were generally compliant with the VHA directive.⁵ However, the OIG determined that water temperatures were not being consistently sustained at 124 degrees Fahrenheit or higher to inhibit *Legionella* growth in hot water systems.⁶

Facility leaders failed to ensure that EMS housekeeping staff received standardized training in cleaning procedures, which may have contributed to an increase in *C. difficile* infections. Despite the efforts made by facility staff to decrease the number of *C. difficile* infections, the infections continued.⁷

OIG staff reviewed the facility's main SPS storage room daily temperature and humidity monitoring log sheets that were available for calendar year 2017, and identified eight months without consistent documentation of monitoring, two months in which temperature did not meet parameters, and three months in which humidity did not meet parameters.⁸ OIG staff reviewed

⁴ VHA Directive 1061, *Prevention of Healthcare-Associated Legionella Disease and Scald Injury from Potable Water Distribution Systems*, August 13, 2014.

⁵ VHA Directive 1061. Actions included isolating the involved water circuits and closing rooms with attempts to remediate and retest for evidence of resolution.

⁶ VHA Directive 1061. "Water temperatures at 124 degrees Fahrenheit (°F) (51.1 degrees Celsius (°C)) or higher are necessary to inhibit *Legionella* growth in hot water systems."

⁷ Facility actions included the availability of bleach wipes, prolonged isolation of patients with *C. difficile*, and EMS housekeeping staff training.

⁸ VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016, outlines temperature parameters as 66°F to 75°F and humidity parameters as 30 to 55 percent. DUSHOM memorandum, Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage, September 5, 2017, provided updated requirements for clean and sterile storage rooms and lists the temperature parameters as 66°F to 72°F and the humidity parameters as 20 to 60 percent.

biological spore testing results for steam sterilizers from January 2016 through December 2017 and identified a positive biological spore test result during November 2016 without the documented corrective actions required by the VHA directive.⁹ In addition, OIG staff reviewed the January and August 2017 main SPS storage room air change and pressure reports and identified that the air change passed; however, the pressure failed for both dates. Facility staff were unable to provide documentation for corrective actions.

From May 9, 2016, through March 12, 2018, the OIG found 534 facility staff members were deficient in the required bloodborne pathogen training. The Interim Facility Director informed the OIG that the training needs were reviewed with the Executive Team in April 2018, and the facility's Assistant Director was reviewing staff training requirements with the Chief of EMS at least weekly for progress.

The VA Office of Operational Analytics and Reporting adapted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA.¹⁰ The facility's healthcare associated infections measured under SAIL were generally underperforming VHA's national averages. Facility leaders were instituting specific programs to address higher infection rates, but with limited impact at the time of the OIG review.

Facility leaders were aware of the six consultative EOC visits from February 2015 through March 2018.¹¹ The six visit reports identified 196 findings, with the common findings being a lack of cleanliness, EMS standard operating procedures, and EMS staff training and competencies. Veterans Integrated Service Network (VISN) 22 and facility leaders were aware of EOC and related concerns and either did not fully address or did not effectively implement actions to address the concerns.

Inpatient facility provider availability was limited due to hospitalist staffing shortages and limited flexibility of scheduling for nocturnists.

Although Mental Health Service leaders had improved staffing levels and implemented measures to improve access to services, the OIG identified continued staffing issues related to vacancy rates and challenges in filling vacant positions. In addition, review of the Mental Health Service

⁹ VHA Directive 1116(2). "A biological indicator (BI) is a sterilization process monitoring device consisting of a standardized, viable population of microorganisms (usually bacterial spores) known to be resistant to the mode of sterilization being monitored."

¹⁰ SAIL is a performance model used by VHA with nine quality domains and one efficiency domain. The SAIL model uses a star ranking system to designate a facility's performance in individual measures, domains, and overall quality as compared to other VA medical facilities. VHA Support Service Center (VSSC). *The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual*. Accessed on April 16, 2017 from an internal VA website.

¹¹ The six consultative visits were completed by Environmental Programs Service staff, VISN staff, National Infection Diseases Service staff, and VHA staff.

performance data showed that since the third quarter of fiscal year 2014, the facility has been in the lowest 20 percent of VA facilities.

The OIG was unable to determine whether patients and staff were exposed to biohazard residue in the inpatient dental clinic. Interviews with staff revealed conflicting reports regarding the content of the leaks in the clinic. However, the OIG substantiated that EMS staff were not routinely cleaning the inpatient dental clinic.

The OIG made 11 recommendations to the Facility Director related to EOC practices; EMS standard operating procedures, training, and competencies; infection prevention controls; hospitalist and nocturnist recruitment; review of mental health staffing and recruitment; and implementation of recommendations from the Environmental Service Program. The OIG made one recommendation to the Facility Chief of Staff and Associate Director of Patient Care Services related to clinician notification of positive water testing. The OIG made two recommendations to the VISN 22 Director related to implementing actions from previous reviews and development of a comprehensive EOC policy.

Comments

The VISN and Facility Directors concurred with the recommendations. (See Appendixes B and C, pages 42–49 for the Directors’ comments.) The OIG considers all recommendations open. Action plans that lacked specific detail were discussed with the Facility Director and the OIG will monitor implementation during the follow-up process until identified deficiencies are resolved.



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Abbreviations

BHIP	Behavioral Health Interdisciplinary Program
CBOC	community based outpatient clinic
<i>C. difficile</i>	<i>Clostridium difficile</i>
CEOC	Comprehensive Environment of Care
EBT	evidence based therapy
EHR	electronic health record
EMS	Environmental Management Service
EOC	environment of care
EPS	Environmental Program Service
FTE	full-time employee equivalent
FY	fiscal year
MHS	Mental Health Service
MOD	medical officer of the day
OIG	Office of Inspector General
SAIL	Strategic Analytics for Improvement and Learning
SOP	standard operating procedure
SPS	Sterile Processing Service
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Congressmen Pete Aguilar and Mark Takano to review concerns related to environment of care (EOC), infection control practices, provider availability, and leadership responsiveness at the VA Loma Linda Healthcare System, (facility), California.

Background

The facility, part of Veterans Integrated Service Network (VISN) 22, is a level 1b, high-complexity medical center that consists of the Jerry L. Pettis Memorial VA Medical Center, the Loma Linda VA Ambulatory Care Center, and six community based outpatient clinics, and is affiliated with the Loma Linda University. In fiscal year (FY) 2017, the facility served 72,459 patients and had a total of 269 operating beds, including 159 inpatient beds and 110 community living center beds.

Environmental Management Service

According to Veterans Health Administration (VHA) policy, the Environmental Programs Service (EPS) provides oversight and operational guidance to the Environmental Management Service (EMS) and related health care environmental program functions at VHA facilities. In addition, EPS develops management systems and procedures to ensure that EMS functions are effectively implemented and maintained at each VA medical facility.¹² In this effort, EPS developed the EMS Sanitation Procedure Guide (EMS Guide) to standardize guidelines and sanitation practices that can be tailored to each facility.¹³

VHA policy outlines that all facilities have appropriate systems in place to meet The Joint Commission EOC standards, as well as VHA requirements for providing a safe, clean, and high-quality care environment.¹⁴ The VHA EOC program is referred to as the Comprehensive Environment of Care (CEOC) Program.¹⁵

¹² VHA Directive 1850, *Environmental Programs Service*, March 31, 2017.

¹³ VHA Environmental Management Service, *Sanitation Procedure Guide*, 2016.

¹⁴ VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016; The Joint Commission is an independent, not-for-profit organization, that accredits and certifies health care organization and programs in the United States. Accreditation is recognized as a symbol of quality that reflects an organization's commitment to meeting performance standards.
<https://www.jointcommission.org/about-us/about-the-joint-commission-main.aspx>. (The website was accessed on May 10, 2018.)

¹⁵ VHA Directive 1850.

According to VHA policy, the Facility Director is responsible for maintaining a safe, sanitary, and healing environment.¹⁶ In addition, the facility's Chief of EMS ensures a state of physical and biological cleanliness and safe conditions for patients, visitors, and employees through proper handling of waste materials, soiled textiles, and equipment.¹⁷

Infection Control Practices

VHA policy requires that each VA medical facility establish an Infectious Diseases Program and an effective Infection Prevention and Control Program.¹⁸ These programs are for the diagnosis and treatment of infectious diseases pathology, and to support facility-wide efforts to prevent and/or reduce the transmission of infectious diseases.¹⁹ The programs have a wide range of functions, including consultation, infection surveillance, collection of specimens, internal reporting, and educational activities. The programs also work collaboratively with other services within VA medical facilities to establish policies, procedures, and guidelines for a clean and sanitary environment, including guidance on the decontamination and sterilization of medical equipment, the separation of contaminated supplies from clean, and the cleaning and disinfecting of patient care areas.²⁰

*Legionella*²¹

Legionella bacteria are known to be present widely in nature, particularly in aquatic environments, but also in soil.²² Because *Legionella* is widespread in nature, its periodic introduction into building water systems is difficult to prevent. Low numbers of the organism may enter buildings from public water sources and colonize water pipes. *Legionella* thrives in the biofilm that lines water pipes and can proliferate there.²³ Clinical risk of infection is increased when conditions for growth are optimal. Mitigation efforts are undertaken with the goal of maintaining an acceptably low level of risk.

¹⁶ VHA Directive 1850.

¹⁷ VHA Directive 1850.

¹⁸ VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.

¹⁹ VHA Directive 1131.

²⁰ VHA Environmental Management Service, *Sanitation Procedure Guide*, 2016.

²¹ VA Office of Inspector General, *Healthcare Inspection –Prevention of Legionnaires' Disease in VHA Facilities*, Report No. 13-01189-267, August 1, 2013; VA Office of Inspector General, *Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities*, Report No. 07-00029-151, June 20, 2007.

²² U.S. Environmental Protection Agency, *Legionella: Ground Water and Drinking Water*.

<https://www.epa.gov/ground-water-and-drinking-water/legionella>. (The website was accessed on February 26, 2019.)

²³ Fields, Barry S.*, Robert F. Benson, and Richard E. Besser, "Legionella and Legionnaires' Disease: 25 Years of Investigation," *Clinical Microbiology Reviews*, 15, No. 3 (July 2002): 506–26.

Legionella mitigation can include monitoring for its presence in the environment through routine cultures of water from water outlets such as faucets. The use of environmental cultures requires strict attention to procedures for the handling of samples and specialized laboratory testing. The facility Water Safety Committee must review any results from water testing for *Legionella* and document corrective actions that were initiated for maintaining water temperature and other measures to inhibit *Legionella* growth.²⁴

Human disease caused by *Legionella* is referred to as legionellosis, which manifests either as a self-limiting illness known as Pontiac fever or as Legionnaires' Disease, a serious and potentially fatal infection of the lungs and other organs. Pneumonia is the most common manifestation of Legionnaires' Disease.

Clinicians must consider the possibility of Legionnaires' Disease whenever patients present with pneumonia, especially if the pneumonia is severe or the patient has recently been hospitalized. Testing in most cases can be easily accomplished with a simple urine test. Facility leaders are responsible to notify clinicians involved in direct patient care of positive water testing results.²⁵

When patients exhibit signs or symptoms that are suggestive of pneumonia, clinicians may initiate antibiotic therapy empirically (based upon symptoms and the clinician's suspicion of pneumonia) while laboratory test results are pending.

Hospitalists and Nocturnists

Physicians who primarily provide general medical care to patients in a hospital or inpatient setting are referred to as "hospitalists."²⁶ The OIG was informed that each hospitalist works individually and is assigned to accept patient admissions for a seven-day period from 8:00 a.m. to 8:00 p.m. followed by seven days off the schedule. Hospitalists who work at night are referred to as "nocturnists." The facility nocturnists report to the Chief of the Emergency Department and have a dual role of providing patient care in the emergency department and performing inpatient

²⁴ VHA Directive 1061, *Prevention of Healthcare-Associated Legionella Disease and Scald Injury from Potable Water Distribution Systems*, August 13, 2014. Water temperatures at 124 degrees Fahrenheit (°F) (51.1 degrees Celsius (°C)) or higher are necessary to inhibit *Legionella* growth in hot water systems.

²⁵ VHA Directive 1061.

²⁶ Hospitalists are "physicians whose primary professional focus is the general medical care of hospitalized patients". <https://www.the-hospitalist.org/hospitalist/article/123072/what-hospitalist>. (The website was accessed on May 23, 2018.)

medical admissions from 8:00 p.m. to 8:00 a.m. Hospitalists also serve as attending physicians on the facility's four Medical Officer of the Day teams teaching medical residents.²⁷

Mental Health Access and Staffing

VHA policy delineates the essential components of the nationally implemented mental health program to ensure that all veterans have access to needed mental health services.²⁸ Mental health access encompasses the timely availability of qualified providers to deliver services. Access includes provider availability to evaluate and establish treatment plans with new patients, provide treatment for established patients at a frequency and duration necessary for the treatment to be effective, and provide urgent or emergency services for patients presenting in crisis or with heightened risk for suicidality. Maintaining timely access to services requires a balance between the available mental health provider resources (supply) and the patients in need of those services (demand), as well as efficient use of the available mental health provider resources. Adequate staffing is necessary to ensure timely mental health access.

VHA Performance Data

The VA Office of Operational Analytics and Reporting adapted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA.²⁹ This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one way to “understand the similarities and differences between the top and bottom performers” within VHA and identify potential areas for improvement.³⁰ VHA facilities with a 5-star in quality rating are performing within the top 10 percent, whereas 1-star in quality

²⁷ A Medical Officer of the Day is the designated responsible physician/practitioner (with Attending back up) or team who is physically present in an inpatient system. VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010. This handbook expired the last working of August 2015 and has not been recertified. The attending is a medical doctor responsible for the overall care of a patient in a hospital or clinic setting. The attending physician supervises and teaches medical students, interns and residents involved in patient care. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/attending-physician>. (The website was accessed on June 8, 2018.)

²⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This handbook was scheduled for recertification on or before the last working date of September 2013, but has not been recertified.

²⁹ SAIL is a performance model used by VHA with nine quality domains and one efficiency domain. The SAIL model uses a star ranking system to designate a facility's performance in individual measures, domains, and overall quality as compared to other VA medical facilities. VHA Support Service Center (VSSC), *The Strategic Analytics for Improvement and Learning (SAIL) Value Model*.

³⁰ VHA Support Service Center, the Strategic Analytics for Improvement and Learning (SAIL) Value Model, this is an internal site not accessible to the public. (The website was accessed on August 7, 2018.)

facilities are performing within the bottom 10 percent. As of the end of FY 2017, the facility received a rating of 1-star for overall quality.

Request for Review

At the request of Congressmen Pete Aguilar and Mark Takano, the OIG conducted a healthcare inspection at the facility.

Based on the information received on February 8, 2018, from congressional staffers, OIG leaders identified the following group of issues to review:

- EOC including availability of bedpans and urinals
- Infection control practices
 - *Legionella* infection and water testing
 - Clostridium difficile (*C. difficile*) infections³¹
 - Sterile Processing Services (SPS) controls (temperature and humidity, biological spore testing, and air change and pressure)
 - Bloodborne pathogens training
 - Performance data related to infection control practices
- Leadership responsiveness to EOC concerns
- Hospitalists and nocturnists availability
- Mental Health Service staffing, access, and performance data

Allegations

In addition to the issues above, in April 2018, the OIG received allegations related to the inpatient dental clinic patients and staff exposure to biohazard residue and EMS staff not routinely cleaning the area.³²

Prior OIG Report

In a prior OIG review, *Clinical Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California*, Report No. 16-00579-293 published on July 31, 2017, the OIG determined the EOC and Infection Control Committee meeting minutes did not have consistent and complete documentation. The recommendations included the EOC Committee meeting minutes consistently document discussion of EOC rounds deficiencies, corrective actions taken

³¹ *C. difficile* is a spore-forming bacterium that can readily survive on surfaces for extended periods of time. Infection can be spread by touching contaminated surfaces and ingesting spores. *C. difficile* spores are difficult to eliminate and are not destroyed by alcohol-based hand sanitizers. <https://www.niaid.nih.gov/research/clostridium-difficile>. (The website was accessed on January 8, 2019).

³² The inpatient dental clinic is an area designated to provide dental care to inpatients.

to address identified deficiencies, and tracking of corrective actions to closure, and ensure Infection Control Committee meeting minutes document actions and the follow-up on actions implemented to address identified problems.³³ These recommendations are closed.

Scope and Methodology

The OIG initiated the inspection on February 12, 2018, and conducted an initial unannounced site visit March 12–15, 2018.

During the unannounced March 12, 2018, site visit, the OIG team conducted an EOC inspection that focused on the overall cleanliness of the facility including: patient care areas, unit medication rooms, nutrition areas, clean and dirty storage areas, central distribution sterile supply room, patient rooms, outpatient waiting areas, and outpatient procedure rooms. The team also inspected non-patient care areas where patients and visitors have access, such as elevators, hallways, and stairwells. OIG team met with 16 inpatients and five nursing staff members to discuss concerns regarding problems with requesting and receiving bedpans and urinals. During the unannounced March 13, 2018, site visit, the team conducted an EOC inspection at the Ambulatory Care Center.

On May 22, 2018, OIG team conducted a second visit to assess allegations regarding inpatient dental clinic patients and staff exposure to biohazard residue and EMS staff not routinely cleaning the area.³⁴

The OIG team interviewed the Facility Director, Interim Facility Director, Associate Director, Acting Chief of Staff, Associate Director for Patient Care Services, Assistant Director, Chief of Quality Management, Chief and Assistant Chief of EMS, Chief of Facility Management Service, Chief of Maintenance and Operations, EOC Coordinator, Chief of Infectious Disease, Chief Hospitalist, Chief of Mental Health Service (MHS) and MHS staff, Occupational Medicine Staff, and other clinical and management staff. The team also interviewed the Chief of Dental Service and dental staff, and communicated with the complainant to clarify the allegations related to the inpatient dental area.

The OIG interviewed VISN 22 staff including the Acting Director, Deputy Director, Executive in Charge, Network Redesign, Quality Management Officer, and Deputy Quality Management Officer. The OIG also interviewed VHA EPS staff and National Infectious Diseases Service staff.

³³ VA Office of Inspector General, *Clinical Assessment Program Review of the VA Loma Linda Healthcare System*. Loma Linda, California, Report No. 16-00579-293, July 31, 2017.

³⁴ Facility leaders accompanied the OIG to reassess specific EOC related concerns identified in the March review.

The OIG team reviewed VHA and facility policies and procedures, committee meeting minutes and reports, and patient data from the VA Corporate Data Warehouse.³⁵

The team reviewed infection control practices as it relates to *Legionella* infection and water testing, *C. difficile* infection, bloodborne pathogens training, and SPS controls (temperature and humidity controls, biological spore testing, and air change and pressure).

To identify patients that may have developed *Legionella* infection, the OIG reviewed data from the facility's Pathology and Laboratory Service. The data contained a list of 391 patients who were tested for *Legionella* from October 2015 to September 2017.

To further evaluate facility's *Legionella* infection data, the OIG medical consultant conducted an independent analysis of data from the VA Corporate Data Warehouse. The data contained a list of 118 patients who died from pneumonia as a primary or secondary cause of death in FYs 2016 and 2017. The medical consultant grouped the patients' admitting diagnoses into respiratory conditions including pneumonia (from unidentified organisms), hypoxia, unexplained shortness of breath, sepsis, and shock. Patients who did not have an admitting diagnosis related to respiratory concerns, such as osteomyelitis, cardiac arrest, dementia, acute renal failure, colitis, atrial fibrillation, urinary tract infection, and hospice were eliminated. The medical consultant identified 28 of 118 patients who were admitted for a respiratory condition (or potential respiratory concern) and died of pneumonia as a primary or secondary cause of death. Twenty-two of the 28 patients did not have *Legionella* testing. The medical consultant conducted an in-depth electronic health record (EHR) review of the 22 patients to evaluate whether the clinical circumstances may have warranted *Legionella* testing.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

³⁵ VA Corporate Data Warehouse is a centralized data repository that contains VA clinical, administrative, and financial data. Accessed on May 10, 2018, from an internal VA website.

Inspection Results

Issue 1: EOC

The facility maintained inconsistent levels of cleanliness within inspected areas of the main hospital building. At the Ambulatory Care Center, the OIG identified three EOC cleanliness concerns.

VHA policy requires “a safe, clean, functional, and high-quality environment for Veterans, their families, visitors, and employees in VHA healthcare facilities...”³⁶

EOC Inspection Results

Main Hospital Building

On March 12, 2018, the OIG conducted an unannounced inspection of the main hospital building. The OIG team inspected areas including inpatient units; patient, medication, nutrition, sterile supply, and outpatient procedure rooms; and clinic waiting areas. In general, the OIG team found the facility’s EOC was not clean and furnishings were in need of repair.³⁷

Ambulatory Care Center

On March 13, 2018, the OIG team inspected outpatient waiting areas, procedure rooms, and medication rooms at the Ambulatory Care Center. The outpatient waiting areas were clean; one outpatient procedure room and two medication rooms were not clean.

Contributory Factors to the Facility’s Lack of Cleanliness

During the EMS managers’ interviews, the OIG identified potential factors that may have contributed to the lack of cleanliness at the facility.

Lack of Consistent EMS Leadership

From March 2013 through April 2018, five different individuals were assigned to the Chief of EMS position. For a three-year period, from March 2013 through September 2016, the facility’s Chief of EMS was reassigned to a different role. The Nurse Executive reported that a permanent Chief of EMS was assigned in March 2017; however, the individual left on extended leave in July 2017 and then was detailed to another position. The Nurse Executive stated that, during the Chief of EMS’s leave, various individuals served as acting Chiefs of EMS.

³⁶ VHA Directive 1608, *Comprehensive CEOC Program*, February 1, 2016.

³⁷ Facility leaders observed EOC findings with the OIG team.

The Chief of EMS is responsible for coordinating “a complete program that includes but is not limited to the development and maintenance of standards for cleanliness and sanitation, frequency of cleaning, methods, procedures, necessary supplies, and safety precautions to be followed.”³⁸

Lack of Facility-Wide Policies Regarding Cleanliness and Standard Sanitation Practices

The facility did not have a written policy establishing a CEOC Program as required by VHA policy.³⁹ The facility’s Assistant Director and Safety Manager provided the OIG with draft policies for facility-wide cleanliness and sanitation, and CEOC; however, the policies had not been implemented.

Lack of EMS Standard Operating Procedures

The OIG found that EMS leadership did not maintain a complete set of updated standard operating procedures (SOPs) for EMS housekeeping staff to follow when cleaning and sanitizing the facility.⁴⁰

The position description for the Chief of EMS indicates that the incumbent is responsible for coordinating “a complete program that includes but is not limited to the development and maintenance of standards for cleanliness and sanitation, frequency of cleaning, methods, procedures, necessary supplies and safety precautions to be followed.”⁴¹ The Assistant Chief of EMS is responsible for ensuring the service has policies, procedures, and standards for cleanliness and sanitation.⁴²

OIG team reviewed 54 EMS SOPs provided by the Assistant Chief of EMS and determined that the cover page to the SOPs was dated (November 27, 2017) and signed by the Chief of EMS and a representative from the Infection Control Committee. However, the 54 SOPs were not individually signed. The Assistant Chief of EMS informed the OIG team that the “SOP’s were not valid because they had not been signed by the Chief of EMS along with the Chief of Infection Control.” In May 2018, the Chief of EMS informed OIG staff that the SOPs were being

³⁸ Position Description, *Hospital Housekeeping Office*, dated November 8, 2016. From the position description, the organization title is listed as Chief, EMS.

³⁹ VHA Directive 1608.

⁴⁰ Standard operating procedures are established guidelines or procedures for the performance of specific tasks to ensure that the tasks are performed in the same manner each time.

⁴¹ Position Description, *Hospital Housekeeping Office*, dated November 8, 2016. From the position description, the organization title is listed as Chief, EMS.

⁴² Position Description, *Assistant Hospital Housekeeping Office*, dated April 15, 2015. From the position description, the organization title is listed as Assistant Chief, EMS.

updated; however, as of October 2018, the facility did not have properly dated and signed EMS SOPs.

The OIG determined that facility leaders, and the Chief and the Assistant Chief of EMS failed to ensure that EMS housekeeping staff had SOPs in place that were approved according to facility expectations.

Failure to Adhere to EMS Processes for Evaluating the Level of Competence of EMS Housekeeping Staff

EMS leaders did not evaluate the level of competency of EMS housekeeping staff to ensure they had the knowledge and skills to properly perform their duties.

The EMS Guide defines competence as “the ability to perform procedures safely, correctly and legally.” The EMS Guide provides guidance for EMS services to evaluate the competency level of EMS staff after 30 days of an assignment or reassignment and annually, in conjunction with employee performance reviews. It also provides standardized templates for supervisory staff to evaluate “service/unit/position specific competencies” and SOP competencies.

The Assistant Chief of EMS, who is responsible for monitoring performance and training, provided the OIG with 10 EMS housekeeping staff competency folders for review.⁴³ The documents had not been reviewed or signed by the EMS staff members and the unsigned competency sheets were incomplete.

The Nurse Executive stated that EMS “competencies should be looked at annually” though acknowledged an issue with locating completed EMS housekeeping staff competencies starting in June 2016. The OIG was informed that the Assistant Chief of EMS was initially detailed to the facility from another VA facility in December 2016 and there were no EMS housekeeping staff competencies at that time. The Assistant Chief of EMS did not review staff competencies until April 2017 when permanently assigned to the position. According to the Nurse Executive, the Acting Chief of EMS detailed to the service from July through September 2017 did not find completed competencies for EMS housekeeping staff. The Nurse Executive developed a plan with the Acting Chief of EMS to bring in subject-matter experts to facilitate training for the EMS housekeeping staff and complete the competency evaluations. The Nurse Executive provided documentation of discussion of the plan and other trainings but was unable to provide evidence that the trainings took place.

During the March 2018 OIG inspection, the Nurse Executive stated that even with the 2017 training, it could not be said that 100 percent of EMS housekeeping staff had current

⁴³ Position Description, *Assistant Hospital Housekeeping Office*, dated April 15, 2015. From the position description, the organization title is listed as Assistant Chief, EMS.

competencies. When OIG staff asked the Nurse Executive why EMS housekeeping competencies had not been validated, the Nurse Executive stated, “I just did not do it.”

Failure to Track EMS Education and Training

EMS leaders did not track education and training for housekeeping staff to ensure they had the knowledge and skills to clean and maintain the facility.

The EMS Guide indicates that service-level training will be conducted “in a professional manner that meets the needs of the employees, training requirements, and mandates governing Environmental Management Services, specifically new employee orientation.”⁴⁴ All employees will receive mandatory annual training and “documentation of training will be maintained by the service or recorded in VA Talent Management System.”⁴⁵

The Assistant Chief of EMS reported that training modules were purchased and used by EMS housekeeping staff from December 2016 through March 2017 and reinstated in April 2017.⁴⁶ However, the OIG was unable to find documented evidence that EMS used the training modules.

During an interview, the Assistant Chief of EMS stated that “I have not had time to conduct trainings because I’ve been busy trying to get the [facility] clean.” The Assistant Chief of EMS acknowledged using town hall meetings to train groups of employees and provided individual training as inspections were conducted, however these training sessions were not documented.

Ongoing Challenges in EMS

During onsite interviews in March 2018, the Facility Director and senior leaders informed the OIG of ongoing challenges with EMS to include low pay, staff turnover, construction, and changes in EMS supervision. The Facility Director and senior leaders described steps to improve EOC to include: (a) a contract for a cleaning crew to supplement regular EMS staff, (b) a contract for deep cleaning in the main facility, (c) borrowing staff from other VA Medical Centers to supplement EMS staffing, (d) implementing mandatory EMS overtime, and (e) having consultative visits each year to review EMS.

Inadequate Supply of Bedpans and Urinals

On the inspected inpatient units, the OIG found a readily available supply of bedpans and urinals. In addition to inspecting supply and storage rooms, the OIG team interviewed patients and nursing staff to gain their perspective on the availability of bedpans and urinals. The 16

⁴⁴ VHA Environmental Management Service, Sanitation Procedure Guide, 2016.

⁴⁵ VHA Environmental Management Service, Sanitation Procedure Guide, 2016. The Talent Management System offers computerized training for VA employees and staff.

⁴⁶ There is an unexplained one-month gap for the training modules.

patients interviewed stated that they had not experienced problems with requesting and receiving bedpans or urinals during their stay. The five nursing staff members did not report a shortage of bedpans and urinals.

Issue 2: Infection Control Practices

The facility had inconsistent infection control practices related to *Legionella* reporting to clinical staff and sustainment of water temperature, *C. difficile* infection, SPS controls documentation, and bloodborne pathogens training.

Legionella Infection and Water Testing

The facility generally followed Legionella testing and took actions to remediate positive tests according to VHA Directive 1061. However, the facility did not have a process to communicate positive testing to clinical providers.⁴⁷

Patient Testing

The OIG reviewed data from the facility's Pathology and Laboratory Service that contained a list of 391 *Legionella* urinary antigen tests performed from October 2015 through September 2017.⁴⁸ The OIG team identified two patients who had positive urinary antigen tests. The OIG medical consultant reviewed the two patients' EHRs and determined that the patients did not acquire *Legionella* infections at the facility.⁴⁹

- In 2017, Patient 1 was diagnosed with *Legionella* pneumonia and hospitalized at a non-VA hospital two months prior to admission to the facility for vomiting. The positive *Legionella* urinary antigen persisted on admission.
- In 2017, Patient 2 was diagnosed with pneumonia at the facility's emergency department and *Legionella* testing was positive on admission. At the time of the emergency department visit, the patient reported living in a mobile home with the water source from a community well and tank system.

⁴⁷ VHA Directive 1061.

⁴⁸ According to the Centers for Disease Control, "The most commonly used laboratory test for diagnosis of Legionnaires' disease is the urinary antigen test, which detects a molecule of the *Legionella* bacterium in urine." <https://www.cdc.gov/legionella/clinicians/diagnostic-testing.html> (The website was accessed on January 9, 2019.)

⁴⁹ The OIG team was provided with an additional example of an individual in a training position who was allegedly exposed to *Legionella* and tested negative with a urinary antigen test at the facility; however, the test was completed soon after the alleged exposure. The individual was evaluated at a non-VA hospital and was found to have a positive antibody test, which was not conclusive for an active *Legionella* infection. However, the individual was treated with broad antibiotics that treated *Legionella* and other infections. Attempts to clarify this individual's subsequent diagnosis and management were unsuccessful.

Both patients were admitted to the facility, received treatment, and were discharged in stable condition.

To further evaluate facility *Legionella* testing, the OIG reviewed the EHRs of 22 patients who had pneumonia as a primary or secondary cause of death and no *Legionella* testing.⁵⁰ The OIG determined that the *Legionella* urinary antigen test was not indicated in the 22 patients.

Although the OIG did not find a specific instance of inappropriate *Legionella* testing, the OIG found that facility leaders did not have a standardized process for notifying clinical staff of *Legionella* water testing results.

According to VHA policy, to increase diagnostic awareness, the Facility Chief of Staff and Associate Director of Patient Care Services are responsible for ensuring that clinical staff involved with direct patient care are notified when (1) “cases of definite or possible HCA LD [healthcare acquired *Legionella* disease] are identified...” and (2) “routine environmental water testing is positive for *Legionella*...”

Infectious Disease staff informed the OIG that relaying positive *Legionella* test results to clinical staff could be improved. The facility Water Safety Committee and the Infection Control Committee meeting minutes did not document notification of positive *Legionella* water testing to clinical staff. In addition, facility leaders failed to provide clinical staff education about how to interpret *Legionella* results. Positive *Legionella* tests in the water system, even if completed under routine surveillance, may affect clinical staff’s course of action to include increased *Legionella* testing and clinical surveillance for susceptible patients.

Water Testing

VA facilities are required to test water for the presence of *Legionella* and test the temperature of the water in buildings that house patients, residents, or visitors for overnight stays. According to VHA policy, the facility Water Safety Committee is required to meet at least quarterly and is responsible to communicate the results of the water testing reviews to leadership, the Patient Safety Committee, the Infection Control Committee, and other local committees as appropriate.⁵¹

OIG staff reviewed *Legionella* water testing results in buildings and areas subjected to VHA Directive 1061.⁵² The facility leaders’ actions for positive *Legionella* water tests were generally compliant with the VHA directive.⁵³ However, the OIG determined that water temperatures were

⁵⁰ The 22 patients were from FY 2016 and 2017 (see Scope and Methodology section).

⁵¹ VHA Directive 1061.

⁵² VHA Directive 1061.

⁵³ VHA Directive 1061. Actions included isolating the involved water circuits and closing rooms with attempts to remediate and retest for evidence of resolution.

not being consistently sustained at 124 degrees Fahrenheit (°F) or higher to inhibit *Legionella* growth in hot water systems.⁵⁴

The OIG determined that the facility's engineers worked in conjunction with Infection Control Service staff to remediate and retest the water according to the level of risk as required by VHA Directive 1061. The Infectious Disease Chief and the Infection Control nurse directed the closing of inpatient beds associated with the positive *Legionella* testing sites. Leaders did not reopen the inpatient beds until repeat water testing was negative for *Legionella*.

OIG staff reviewed the available Water Safety Committee meeting minutes from October 2015 through September 2017, which indicated that water safety planning was addressed; however, the committee did not meet at least quarterly and did not communicate results to clinical staff per VHA Directive 1061.

C. difficile infection

The OIG determined that facility leaders failed to ensure that EMS housekeeping staff received standardized training in cleaning procedures which may have contributed to an increase in *C. difficile* infections.

The facility's Infection Control Guidelines outlines specific cleaning for rooms designated under certain infection control precautions that would include *C. difficile* infection. The designated rooms should be routinely cleaned with hospital-approved disinfectant. Environmental surfaces that are "high-touch" surfaces (that is, bed rails, bedside tabletops, doorknobs, other commonly used items, and bathrooms) are to be cleaned with each shift. When the patient is discharged, nursing staff will leave the isolation signage on the room door and notify housekeeping to clean the room. The housekeeping staff will remove the sign and notify nursing staff when the room is ready for occupancy.⁵⁵

OIG staff reviewed the facility's Infection Control Committee meeting minutes from October 2015 through September 2017. The meeting minutes contained reports of inadequate EMS cleaning policies and a lack of standardized training in cleaning procedures. Committee members identified these two items as possible causes for the *C. difficile* infections from quarter to quarter.

Infection Control Committee meeting minutes dated May, July, and August 2017 showed actions the facility staff took in an effort to decrease the number of *C. difficile* infections including

- Availability of bleach wipes for cleaning,
- Prolonged isolation of patients with *C. difficile* infection, and

⁵⁴ VHA Directive 1061. "Water temperatures at 124 degrees Fahrenheit (°F) (51.1 degrees Celsius (°C)) or higher are necessary to inhibit *Legionella* growth in hot water systems."

⁵⁵ Infection Control Guidelines Categories of Isolation and Universal/Standard Precautions.

- EMS housekeeping staff training on Clorox cleaning products.

Despite the efforts made by facility staff to decrease the number of *C. difficile* infections, the infections continued. (See Table 1.)

Table 1. *C. difficile* Infections from October 2015 through September 2017

FY	Quarter	Number of <i>C. difficile</i> infections
2016	1	3
2016	2	3
2016	3	8
2016	4	18
2017	1	4
2017	2	15
2017	3	7
2017	4	10

Source: OIG analysis of facility data for *C. difficile* infections

SPS Controls

SPS staff failed to document daily temperature and humidity monitoring and corrective actions for a positive biological spore test as required by VHA directive.⁵⁶ In addition, facility staff did not immediately document a failed annual air flow check in the main SPS storage room that occurred in 2017.

Temperature and Humidity Monitors

The OIG team reviewed the facility’s main SPS storage room daily temperature and humidity monitoring log sheets that were available for calendar year 2017, and determined staff did not consistently document daily temperature and humidity readings, and the SPS storage room did not consistently meet temperature and humidity parameters per VHA’s requirements.⁵⁷

VHA Directive 1761 requires daily monitoring of temperature and humidity of the main SPS storage room. The SPS main storage room needs to have “a stable environment without extreme

⁵⁶ VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

⁵⁷ VHA Directive 1116(2) outlines temperature parameters as 66°F to 75°F and humidity parameters as 30 to 55 percent. DUSHOM memorandum, *Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage*, September 5, 2017, provided updated requirements for clean and sterile storage rooms with the temperature parameters as 66°F to 72°F and the humidity parameters as 20 to 60 percent.

changes in temperature and humidity,” and items stored here “must comply with temperature and humidity requirements in accordance with manufacturer specifications.”⁵⁸

For calendar year 2017, the OIG team reviewed 10 months of temperature and humidity monitoring log sheets and identified eight months without consistent documentation of daily monitoring; two months in which temperature did not meet parameters; and three months in which humidity did not meet parameters.⁵⁹

SPS Biological Spore Testing

OIG team reviewed biological spore testing results for steam sterilizers from January 2016 through December 2017, and identified a positive biological spore test result during the month of November 2016.⁶⁰

According to VHA policy, steam sterilizers must be monitored via biological spore testing at least once every day when they are used, and there must be clear lines of responsibility and accountability established to ensure a standardized process for proper reprocessing and maintenance of reusable medical equipment.⁶¹ VHA policy outlines that a positive biological spore test should be reported immediately to Infection Prevention and Control, the supervisor, SPS, and the Associate Director for Patient Care Services, as well as a written report completed. The written report should include the time, date, description of the sterilizer cycle, and items processed in the sterilizer.⁶² Facility policy requires that a positive biological indicator must be saved and sent to the lab for culturing and verification to determine spore/bacteria growth.⁶³

The OIG team reviewed Infection Control Committee meeting minutes from October 2015 through December 2017 and did not find documented evidence that reflected a discussion of the positive biological spore test result nor documented evidence that a written report was completed.

⁵⁸ VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.

⁵⁹ The facility was unable to provide documentation of daily temperature and humidity monitoring for November and December 2017. The December 24, 2013, DUSHOM memorandum provided interim guidance for clean and sterile storage rooms with the temperature parameters as 72°F to 78°F and humidity parameters as 20 to 60 percent. This was rescinded and replaced in March 2016 with VHA directive 1116(2), which outlines temperature parameters as 66°F to 75°F and humidity parameters as 30 to 55 percent. The DUSHOM memorandum dated September 5, 2017, provided additional interim guidance for clean and sterile storage rooms where the temperature parameters as 66°F to 72°F and the humidity parameters as 20 to 60 percent for clean and sterile storage rooms.

⁶⁰ VHA Directive 1116(2). “A biological indicator (BI) is a sterilization process monitoring device consisting of a standardized, viable population of microorganisms (usually bacterial spores) known to be resistant to the mode of sterilization being monitored.”

⁶¹ VHA Directive 1116(2).

⁶² VHA Directive 1116(2).

⁶³ VA Loma Linda Healthcare System (605) SOP, Positive Load/Recall Procedures.

In an email dated April 19, 2018, an SPS supervisor stated, “there wasn’t any other positive BI’s [biological indicator] for the month of November 2016 leading us to believe that positive load was probably due to user error.”

Air Change and Pressure

The OIG reviewed the main SPS storage room air change and pressure reports for January and August 2017 and identified that the air change passed; however, the pressure failed for both dates. VHA policy indicates that clean and sterile storage locations require at minimum an annual air flow check by the Engineering Service and corrective action taken immediately if not in compliance.⁶⁴

Facility Management Service staff were unable to provide details or references for the pressure failure corrective action. The Facility Management Service staff also could not provide detailed documentation of an annual air flow check for 2016.

During the OIG review in May 2018, Facility Management Service staff stated that air pressure monitoring was discontinued in the main SPS storage room from October 2017 through May 2018. In addition, Facility Management Service staff were under the impression that the storage room was only used for equipment storage and were unaware that sterile supplies were being stored in the room.

During the OIG onsite visit, staff tested the main SPS storage room, which had proper positive pressure. In addition, Facility Management Service staff provided planned actions to ensure air pressure monitoring in the main SPS storage room including

- Adding the main storage room back to the monthly list of air pressure monitoring,
- Instituting a new monthly review to formally examine the testing results and follow-up, and
- Utilizing the work order system to maintain documentation on repairs.

Bloodborne Pathogens Training

Facility staff members did not consistently complete bloodborne pathogens training from May 2016 through March 2018 as required.

Facility policy requires that all employees receive bloodborne pathogens training at the time of initial assignment, and annually thereafter. All supervisors and section chiefs are to ensure that employees have completed training.⁶⁵

⁶⁴ VHA Directive 1116(2), *Sterile Processing Services, (SPS)*, March 23, 2016. “Air flow is carefully controlled in SPS to minimize the movement of microorganisms from dirty areas to clean areas.”

⁶⁵ Healthcare System (HCS) Policy 11-70, *Bloodborne Pathogens Exposure Control Plan*, December 1, 2016.

The OIG reviewed a list of bloodborne pathogens training for facility staff from May 9, 2016, through March 12, 2018, and found 534 of the facility staff members were deficient in the required bloodborne pathogens training. Talent Management System data for bloodborne pathogens training showed 131 staff deficient from May through December 2016, 243 staff deficient in calendar year 2017, and 160 staff deficient from January through March 2018.⁶⁶

The Interim Facility Director informed the OIG that the training needs were reviewed with the Executive Team in April 2018, and the facility's Assistant Director was reviewing staff training requirements with the Chief of EMS at least weekly for progress.

Performance Data

The OIG found that the facility's healthcare associated infections measured under SAIL were generally underperforming VHA's national averages. Facility leaders acknowledged and the Infection Control and Quality Council committees meeting minutes contained documentation of facility performance for FY 2016 and 2017. Facility leaders were instituting specific programs to address higher infection rates but with limited impact at the time of the OIG inspection.

The OIG reviewed facility SAIL data from October 2015 through September 2017, for healthcare associated infections including catheter associated urinary tract infections, ventilator associated events, and central line associated bloodstream infections. Facility's SAIL data for rates of infection were generally higher than the national average for FYs 2016 and 2017.⁶⁷ Facility leaders acknowledged concerns of the high infection rates. The Facility Director informed, and the OIG observed that dashboards were used to have daily briefings to review infections. Examples of process improvement for SAIL related data include the formation of workgroups for catheter associated urinary tract and central line associated bloodstream infections. These workgroups developed training for new staff and medical residents, monitored the trends of infections, and instituted champions for lowering rates of infection. However, the OIG team found that those additional resources and increased monitoring resulted in limited gains to control the healthcare associated infections measured by SAIL.

Facility nurse managers provided the infection education directly to staff. The facility has an Education Department; however, the educators had a limited role in infection prevention efforts.

OIG team reviewed the Infection Control Committee and Quality Council meeting minutes from October 2015 through September 2017 and identified discussions and education of SAIL

⁶⁶ For this report, facility staff listed did not complete the required training initially or if completed initially, did not complete the required training annually over the time period in this review component.

⁶⁷ The OIG determined that the rates of infection measured quarterly underperformed VHA's national averages for six out of eight quarters for catheter associated urinary tract infections and ventilator associated events, and five out of eight quarters for central line associated bloodstream infections.

infection related data. However, the meeting minutes did not consistently reflect follow-up on actions implemented to address the identified problems and this finding was previously identified in the March 2017 OIG review.⁶⁸

Issue 3: Leadership Responsiveness to EOC Concerns

The OIG determined that VISN 22 and facility leaders were aware of EOC and related concerns, and either did not fully address or did not effectively implement actions to address the concerns. The OIG determined that actions, if taken, were not fully effective as evidenced by the number of reoccurring and ongoing findings from EOC-related consultative visits.

VHA policy states that each VISN Director or designee is responsible for ensuring that the VISN has a written policy that establishes and maintains a CEOC.⁶⁹ As of May 15, 2018, the VISN 22 Deputy Network Director confirmed that there was no VISN-level CEOC policy. In addition, the Facility Director, by VHA policy, is responsible for ensuring that all health care environmental program functions associated with EPS are fully implemented to maintain a safe, sanitary, and healing environment.⁷⁰

Facility leaders were aware of the six consultative visits performed from February 2015 through March 2018 noted in Table 2.⁷¹ The six reports identified 196 findings and the common findings included a lack of cleanliness, EMS SOPs, and EMS staff training and competencies.

⁶⁸ Clinical Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California, Report No. 16-00579-293, July 31, 2017.

⁶⁹ VHA Directive 1608.

⁷⁰ VHA Directive 1850.

⁷¹ The Facility Director was assigned in June 2013 and retired in March 2018.

Table 2. Facility’s EOC-Related Consultative Visits, February 2015–March 2018

Reviewing Body ⁷²	Dates	Total Findings ⁷³
EPS Staff	February 2–6, 2015	20
EPS Staff	March 21–24, 2016	24
VISN Staff	July and August 2016	44
National Infectious Diseases Service Staff	August 15–16, 2017	2
VHA Staff	September 26–28, 2017	95
EPS Staff	March 8, 2018	11

Source: OIG Representation of facility EOC Consultative Visits

VHA’s EPS Director and Deputy Director informed the OIG that the office used a consultative approach over EMS with no enforcement authority if the facility did not comply with recommendations. Facility leaders invite EPS for consultative visits and the results of those consultative visits are shared with facility leaders, but not generally with VISN leaders. VHA leaders directed the March 2018 EPS site visit to the facility, and they identified several EOC-related issues that needed improvement.

The VISN Executive in Charge informed the OIG of awareness of the March 8, 2018, EMS consultative visit and findings. The VISN Executive in Charge visited the facility on March 15, 2018, and instructed staff to clean the facility.

VHA’s National Infectious Diseases Service concluded in its 2017 site visit the facility had issues related to infection control and EOC. The report indicated that the facility was generally dirty. Facility staff provided documentation of a draft action plan incorporating the National Infectious Diseases Service recommendations; however, there was no consistent documentation that ensured all National Infectious Diseases Service recommendations were fully implemented and tracked to completion.

During the March 2018 onsite inspection, the OIG team found a lack of consistent documentation of actions taken to address the reported findings from the consultative visits. The Facility Chief of Quality Management stated that there was no assigned department responsible for the tracking of all external site consultative findings. However, the Chief of Quality Management reported the Interim Facility Director assigned the Quality Management Department the responsibility to consolidate and track all of the external site consultative findings. During the May 2018 OIG visit, the Assistant Director outlined an action plan to address the issues identified in the 2018 EMS site visit. In June 2018, the Assistant Director

⁷² The National EPS Office completed site visits in 2015, 2016, and 2018. Qualified VHA staff completed the 2017 review.

⁷³ For this report, findings are inclusive of the terms: recommendations, standards, observations, or findings.

provided additional information about incorporating the results of the 2017 EMS consultation into their action plans.

The Acting VISN 22 Director, Deputy Director, and Deputy Quality Management Officer informed the OIG that they were aware of general EOC issues at the facility and the Facility Director was taking action to improve the EOC, such as using contracts to assist with EMS staffing. The VISN 22 Quality Management Officer outlined that VISN EMS reviews were completed in July 2016 and August 2016, and cleanliness issues were found throughout the facility. VISN 22 staff did not have documentation of actions taken to remediate the findings.

To further identify facility leaders' involvement with EOC and related processes, OIG staff reviewed the EOC Committee meeting minutes for FYs 2016 and 2017. The EOC Committee meeting minutes did not include consistent discussion of EOC round deficiencies, corrective actions taken to address deficiencies, and tracking corrective actions to closure. A prior OIG review in March 2017 identified the same EOC-related deficiencies.⁷⁴ From interviews, EMS and facility leaders generally relied on face-to-face communication of EOC issues with lack of consistent documentation of action taken to resolve the issues.

The OIG identified that facility leaders did not consistently attend CEOC rounds, and did not ensure that staff consistently addressed CEOC issues identified from these rounds.⁷⁵ OIG staff reviewed CEOC rounding reports from October 2015 through March 2018 and found facility's senior leaders' attendance for CEOC rounds dropped from 89.4 percent in FY 2016 to 84.2 percent in quarters 1–2, FY 2018. VHA policy requires “the CEOC Rounds Team to be led by the facility director or designee who is a member of the Executive Leadership Team, such as the Deputy Director, Associate Director, Chief of Staff, or Nurse Executive.”⁷⁶ VISN 22 leaders informed the OIG that facility senior leaders' attendance should be 90 percent or better for CEOC rounds.

The OIG reviewed documentation from completed EOC rounds from October 2015 through March 2018 and found EOC deficiencies completed or addressed within 14 business days decreased from 94.3 percent in Quarter 1 FY 2016 to 75.8 percent in Quarter 2 FY 2018. The EPS Director stated the target or goal for percent of deficiencies completed or addressed within 14 days is 85 percent.

⁷⁴ Clinical Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California, Report No. 16-00579-293, July 31, 2017.

⁷⁵ VHA Directive 1608. VHA policy defines CEOC Rounds “as recurring facility tours used to determine the presence of unsafe and/or untoward conditions and whether the facility's current processes for managing the environment of care are practiced correctly and are effective.” VHA policy requires facilities to use the CEOC ACT, “a VA intranet-based vehicle for documenting, reporting, and showing trends for facility CEOC Rounds compliance.”

⁷⁶ VHA Directive 1608.

In April 2018, the OIG team interviewed the facility's Safety Manager/EOC coordinator who stated that staff documented EOC rounds using paper checklists, but the results could not be entered into the CEOC Assessment and Compliance Tool (an electronic data software) because there was not administrative access at that time. VHA policy requires the facility director, or designee, ensure the CEOC Assessment and Compliance Tool is used to collect all data associated with CEOC rounds within their facility and a written policy is issued that establishes and maintains a CEOC Program.⁷⁷ The facility's Safety Manager/EOC coordinator who was appointed to the position in January 2018, informed OIG that there was no Safety Manager from 2016 through 2017. Also, the Safety Manager stated that the facility did not have a CEOC policy until a policy was submitted in February 2018.

Issue 4: Hospitalists and Nocturnists Availability

Facility inpatient provider availability was limited due to staffing shortages. When interviewed, the Chief Hospitalist explained that 22 full-time equivalent (FTE) hospitalists were needed to adequately provide patient care; however, current staffing was 13 hospitalists and nine vacancies.⁷⁸ To meet the needs of the inpatient admissions, hospitalists worked their days off and vacations. When the Medical Officer of the Day teams reached the maximum number of admissions governed by the Accreditation Council for Graduate Medical Education, the overflow patients went to the hospitalists.⁷⁹ After the scheduled hospitalists reach their maximum number of patients for admission, the Chief Hospitalist had to provide medical coverage for these patients.⁸⁰

Although the facility had an option to use fee-based hospitalists, OIG staff was informed that the last used fee-based hospitalist was in December of 2017.⁸¹

The Chief of the Emergency Department, who was in charge of the nocturnists, informed OIG inspectors that 2.5 FTE hospitalists were serving as nocturnists and available for patient care seven days a week. However, the Chief indicated that this number did not allow flexibility in scheduling vacations and sick leave.

⁷⁷ VHA Directive 1608.

⁷⁸ FTE is one employee working full time. <https://www.thebalancecareers.com/what-is-a-full-time-equivalent-1669461>. (The website was accessed on February 12, 2019.)

⁷⁹ Accreditation Council for Graduate Medical Education Program Requirements for Graduate Medical Education in Internal Medicine. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_2017-07-01.pdf. (The website was accessed on February 12, 2019.)

⁸⁰ VHA Handbook 1400.01, *Resident Supervision*, December 12, 2012.

⁸¹ According to VA Handbook 5011/27, *Hours of Duty and Leave*, October 21, 2014, Intermittent and Fee Basis Employment are "persons employed on an intermittent basis, per annum fee basis, or lump-sum fee basis, who under [the] authority of 38 U.S.C. 7405 are paid for actual service rendered and therefore their duty schedules shall be determined by procedural requirements issued by the Under Secretary for Health."

The OIG asked the Chief Hospitalist, the Chief of the Emergency Department, and facility leaders about their plans to address the hospitalist and nocturnist staffing shortage. The future plans included

- Four hospitalist applicants who were expected to start at the facility in July 2018,
- Continued interviewing and recruitment of hospitalists to reach the goal of 22 FTEs, and
- Executive Leadership Board approved four FTE hospitalists to lead the Medical Officer of the Day teams (to replace the subspecialty attendings).

The facility funded an increase in nocturnists to three FTE employees to allow for more staffing flexibility. The Chief of the Emergency Department stated that once the hospitalist program was fully staffed, the nocturnists program would move under the Chief Hospitalist.

Issue 5: Mental Health Service Staffing, Access, and Performance Data

The facility had a history of understaffing in the MHS. MHS leaders had improved staffing levels over the past four years and implemented other measures to improve services such as a same day access clinic and use of community care referrals. However, the OIG identified continued staffing issues related to vacancy rates and some challenges or delays in filling vacancies.

Additionally, review of the MHS performance data showed that since the third quarter of FY 2014, the facility has been in the lowest 20 percent of VA facilities.

MHS Staffing

MHS leaders identified understaffing as a primary factor in wait time issues for some mental health services and the facility's low performance on mental health SAIL metrics. When interviewed in April 2018, the Chief of MHS told OIG inspectors that the service was grossly understaffed after starting the position in 2014. The Chief of MHS was able to attain significant increases in approved staffing levels from 214 FTE in 2014 to 340 FTE in 2017. In February 2018, the facility reported a 25 percent vacancy rate across the combined outpatient MHS sections to the VISN. In March 2018, there were 67 vacancies. Despite the increase in approved FTEs, the number of vacancies remained high.

When interviewed, MHS leaders described recruitment efforts for vacant positions, particularly for psychiatrists. Within the preceding two years, the Chief of MHS received approval for salary increases for psychiatrists, which improved recruitment, retention, and staffing. The increased psychiatrist staffing improved distribution of workload among the prescribing providers and reduced turnover for this discipline.

MHS leaders described efforts to ensure timely access to mental health care and identified staffing as a primary factor impacting access. Top priorities were to provide for same day access for urgent mental health services and continuity of mental health treatment for patients identified as being at high risk for suicide. These efforts included re-allocating existing outpatient staff resources to priority services.

MHS Re-allocation of Staff to Access Clinic

Leaders addressed an identified priority for same day access to urgent mental health services with the creation of a same day walk-in mental health clinic (Access Clinic) at the Ambulatory Care Center in January 2017. Staff from the Behavioral Health Interdisciplinary Program (BHIP) were re-aligned to the Access Clinic. However, this re-alignment exacerbated understaffing of the BHIP teams.⁸²

MHS Re-allocation of Staff to Suicide Prevention Programs

Leaders addressed an identified priority of continuity of care for patients identified as being at high risk for suicide or recently discharged from inpatient care by expanding the Suicide Prevention program. To accomplish this, social work staff from other clinical teams were reallocated to four new program areas under Suicide Prevention.⁸³

MHS Access

The OIG reviewed MHS outpatient and inpatient access data. In general, the OIG found the average wait times for a new outpatient intake appointment with a prescribing provider or therapy provider and established patient appointments with BHIP therapy providers at the Ambulatory Care Center exceeded the VHA 30-day timeliness standard.⁸⁴ For specific information about MHS outpatient access data, please see Appendix A.⁸⁵ The OIG reviewed

⁸² BHIP is a team-based treatment approach and staffing model which VHA developed and implemented for providing general outpatient mental health care. VA mental health clinics utilize BHIP teams, consisting of groups of mental health professionals working together, to address the treatment needs for a panel of patients.

⁸³ Although the reallocation presented a problem due to extended staff leave, the facility was able to maintain timely availability with the use of overtime.

⁸⁴ Mental health prescribing providers, including psychiatrists and nurse practitioners, provide pharmacological treatment. Mental health therapy providers, including psychologists and social workers, provide various types of psychotherapy.

⁸⁵ The specific areas that had an average number of days that exceeded the VHA 30-day timeliness standard included: Ambulatory Care Center BHIP prescribing provider intake (51 days), therapy provider intake (60 days), therapy provider (49 days); CBOC BHIP prescribing provider intake (62 days), therapy provider intake (46 days); and Primary Care Mental Health Integration prescribing provider (49 days).

inpatient MHS data and did not find access issues for inpatient psychiatric stabilization due to staffing.

MHS Inpatient Access

For inpatient mental health services, the facility operates a 30-bed inpatient locked psychiatric unit for acute psychiatric needs, with four beds reserved for geriatric psychiatry patients. The OIG reviewed facility data for the first half of FY 2018 and did not find bed closures attributed to short staffing.⁸⁶ MHS leaders reported no identified problems with access for inpatient psychiatric stabilization.

Mental Health Service Performance Data

VHA's SAIL report includes a Mental Health Domain score, which reflected a composite based on a number of different individual metrics, falling under the broad categories of Mental Health Population Coverage, Mental Health Continuity of Care, and Mental Health Experience of Care. The facility's SAIL Mental Health Domain score placed the facility's performance in the lowest 20 percent of VHA facilities on this measure across all quarters since the Mental Health Domain was added to VHA's SAIL report in the third quarter of FY 2014. Review of facility leaders' SAIL briefings and reports on action plans for improvement of SAIL performance confirmed that the senior facility leadership team was aware of the poor performance on Mental Health Quality of Care and Efficiency performance metrics. During interviews with the OIG, the Chief of MHS spoke knowledgeably about actions taken and ongoing efforts to improve performance on mental health SAIL metrics, as well as challenges faced by the service.⁸⁷

Issue 6: Inpatient Dental Clinic

The OIG was unable to determine whether patients and staff were exposed to biohazard residue. There were conflicting reports regarding leaks in the clinic. Staff who were present at the time of the leaks described the fluid as watery or brown in color and reported no patient or staff exposure. One staff member who was not present in the clinic described the leaks as biohazard material with possible patient and staff exposure. The OIG substantiated that EMS staff were not routinely cleaning the inpatient dental clinic.⁸⁸

⁸⁶ A small number of bed closures occurred due to infection control measures.

⁸⁷ OIG staff learned that the Chief of MHS left the facility at the end of April 2018 for another position.

⁸⁸ Occupational Safety and Health Administration (OSHA) identifies an exposure incident as "a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIM), as defined in the standard that results from the performance of a worker's duties." OSHA Fact Sheet. <https://www.osha.gov>. (The website was accessed on May 31, 2018.)

Alleged Exposure of Patients and Staff to Biohazard Residue

OIG staff interviewed two inpatient dental providers who stated that when they arrived at the inpatient dental clinic on March 27, 2018, two separate dental procedure rooms had water on the floor. One dental provider informed the OIG the water appeared to come from a leak in the wall. A second dental provider informed OIG staff that the leak was brown in color and appeared to be coming from the dental chair unit where it connects to the wall. Both dental providers stated that they found the leaks prior to patient procedures and no patients were in the rooms during the leaks. The dental providers reported wearing protective equipment while cleaning up the water, and denied being exposed to bloodborne pathogens, biohazardous waste, blood, or bodily fluids.

One staff member who was not present in the clinic reported a potential biohazard exposure to an infection control clinician who opined there was no patient exposure.

A dental provider identified a second leak on April 3, 2018, and observed a wet floor after running water in “a sink for an extended period of time.” The dental provider reported wearing protective equipment and cleaning up the water using paper towels and denied being exposed to biohazardous waste, blood, or bodily fluids.

The Chief of Dental Service did not have knowledge of exposure incidents in the inpatient dental clinic.⁸⁹ The Safety Manager indicated that it appeared fluid leaks were addressed and repaired, and there was no documented evidence of patient exposure resulting from the leaks in the dental clinic.

Alleged Failure to Routinely Clean the Inpatient Dental Clinic

An unannounced EOC review was conducted of the inpatient dental clinic on May 22, 2018.⁹⁰ OIG staff found:

- Dirt and debris on the floors,
- Dusty cabinets,
- An unemptied trash can,
- Improperly secured wiring and extension cords,
- A sterile instrument set on a dirty rack, and
- An inconsistently completed temperature and humidity checklist.

⁸⁹ The inpatient dental clinic is an area designated to treat inpatients for dental care.

⁹⁰ Additionally, the OIG reassessed specific EOC related concerns to evaluate status from the March review and were accompanied by facility leaders.

The OIG identified that procedure rooms on the unit were closed while the facility conducted *Legionella* remediation. Signage indicating that procedure rooms were not to be used had been removed potentially exposing patients and staff to hazardous conditions. The OIG found that at least one patient was seen in a procedure room at the time the signage was removed. Facility staff provided the name of the patient and the OIG medical consultant reviewed the relevant EHR and determined the patient did not have or develop medical issues because of *Legionella* exposure or infection. While OIG was on site, facility staff replaced the necessary signage.

As outlined in Issue 1, VHA policy requires a safe, clean, functional, and high-quality environment for veterans, their families, visitors, and employees in VHA healthcare facilities.⁹¹ The Chief of Dental Service informed the OIG that providers had reported cleanliness concerns to the Chief of EMS in April 2018. Facility staff provided documentation that routine cleaning by EMS was inconsistent in May 2018 and the Chief of EMS was re-contacted. Quality Management staff followed up on the cleaning issues.

Conclusion

The OIG determined that the facility maintained inconsistent levels of cleanliness within inspected areas of the main hospital building. Additionally, the OIG team identified three EOC cleanliness concerns at the Ambulatory Care Center. Potential factors that may have contributed to the lack of cleanliness at the facility were: (a) lack of consistent EMS leadership, (b) lack of facility-wide policies regarding cleanliness and standard sanitation practices, (c) EMS leaders failed to ensure that EMS housekeeping staff had SOPs in place that were approved according to facility expectations, (d) EMS leaders did not evaluate the level of competency of EMS housekeeping staff, (e) EMS leaders did not track education and training for housekeeping, and (f) ongoing challenges with EMS to include low pay, staff turnover, construction, and changes in EMS supervision.

OIG staff found a readily available supply of bedpans and urinals. The five nursing staff members reported experiencing a shortage of bedpans and urinals in the past but identified no current problems.

To further evaluate facility *Legionella* testing, OIG staff reviewed the EHRs of 22 patients who had pneumonia as a primary or secondary cause of death and no *Legionella* testing. The OIG determined that the *Legionella* urinary antigen test was not indicated in the 22 patients. Although OIG staff did not find a specific instance of inappropriate *Legionella* testing, the OIG found that facility leaders: (a) did not have a standardized process for notifying clinical staff of *Legionella* water testing results, (b) did not ensure that the Water Safety Committee and the Infection Control Committee meeting minutes contained documentation of the notification of positive

⁹¹ VHA Directive 1608.

Legionella water testing to clinical staff, and (c) failed to provide clinical staff education about how to interpret *Legionella* results.

The facility leaders' actions for positive *Legionella* water tests were generally compliant with the VHA policy. However, the OIG determined that water temperatures were not being consistently sustained at 124°F or higher to inhibit *Legionella* growth in hot water systems. Additionally, OIG staff found that facility leaders did not ensure that the Water Safety Committee met at least quarterly and communicated *Legionella* water testing results to clinical staff.

The OIG determined that facility leaders failed to ensure that EMS housekeeping staff received standardized training in cleaning procedures which may have contributed to an increase in *C. difficile* infections. Despite the efforts made by facility staff to decrease the number of *C. difficile* infections, the infections continued.

The OIG found that: (a) SPS staff failed to document daily temperature and humidity monitoring and corrective actions for a positive biological spore test, (b) facility staff did not immediately document a failed annual air flow check in the main SPS storage room that occurred in 2017, (c) staff did not consistently document daily temperature and humidity readings, and (d) SPS storage room did not consistently meet temperature and humidity parameters.

OIG staff reviewed Infection Control Committee meeting minutes from October 2015 through December 2017 and did not find documented evidence that reflected a discussion of the positive biological spore test result nor documented evidence that a written report was completed.

OIG staff reviewed the main SPS storage room air change and pressure reports for January and August 2017 and identified that the air change passed; however, the pressure failed for both dates. The OIG found that Facility Management Service staff were unable to provide details or references for the pressure failure corrective action. The Facility Management Service staff also could not provide detailed documentation of an annual air flow check for 2016. Additionally, the OIG determined that facility staff members did not consistently complete bloodborne pathogens training from May 2016 through March 2018 as required.

The OIG found that the facility's healthcare associated infections measured under SAIL were generally underperforming the VHA's national averages. The Infection Control Committee and Quality Council meeting minutes from October 2015 through September 2017 did not consistently reflect follow-up on actions implemented to address the identified problems and this finding was previously identified in the March 2017 OIG review.

The OIG determined that VISN 22 and facility leaders were aware of EOC and related concerns, and either did not fully address or did not effectively implement actions to address the concerns as evidenced by the number of reoccurring and ongoing findings.

The OIG team found that facility leaders did not ensure: (a) all National Infectious Diseases Service recommendations were fully implemented and tracked to completion, (b) consistent

documentation of actions taken to address the reported findings from the consultative visits, (c) EOC Committee meeting minutes include consistent discussion of EOC round deficiencies, corrective actions taken to address deficiencies, and tracking corrective actions to closure, and (d) facility leaders consistently attend CEOC rounds, and that staff consistently addressed CEOC issues identified from these rounds.

The OIG determined that facility inpatient provider availability was limited due to staffing shortages in hospitalists and limited flexibility of scheduling for nocturnists.

MHS leaders had improved staffing levels over the past four years and implemented other measures to improve services such as a same day access clinic and use of community care referrals. However, the OIG identified continued staffing issues related to vacancy rates and some challenges or delays in filling vacancies.

The OIG was unable to determine whether patients and staff were exposed to biohazard residue in the inpatient dental clinic; however, the OIG did substantiate that EMS staff were not routinely cleaning the inpatient dental clinic.⁹²

⁹² Occupational Safety and Health Administration (OSHA) identifies an exposure incident as “a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIM), as defined in the standard that results from the performance of a worker’s duties.” OSHA Fact Sheet. <https://www.osha.gov>. (The website was accessed on May 31, 2018.)

Recommendations 1–14

1. The VA Loma Linda Health Care System Director ensures implementation of system-wide comprehensive environment of care practices and a safe, sanitary, and high-quality environment consistent with Veterans Health Administration policy.
2. The VA Loma Linda Health Care System Director makes certain that Environmental Management Service managers establish standard operating procedures and consistent processes for staff training.
3. The VA Loma Linda Health Care System Director implements a standardized process and accountability for validating Environmental Management Service staff competencies.
4. The VA Loma Linda Health Care System Director verifies compliance with Veterans Health Administration policies for Sterile Processing Services controls.
5. The VA Loma Linda Health Care System Director complies with Veterans Health Administration policies developed to support Infection Prevention and Control Program issues identified in this report.
6. The VA Loma Linda Health Care System Director ensures that hot water temperature systems are 124 degrees Fahrenheit or higher to inhibit *Legionella* growth.
7. The VA Loma Linda Healthcare System Chief of Staff and Associate Director of Patient Care Services implements a standardized process, consistent with Veterans Health Administration policy, to notify clinical staff involved in direct patient care when routine environmental water testing is positive for *Legionella* to increase diagnostic awareness.
8. The VA Loma Linda Health Care System Director continues to recruit and hire for hospitalist vacancies.
9. The VA Loma Linda Health Care System Director monitors action plans for the Mental Health Strategic Analytics for Improvement and Learning measures.
10. The VA Loma Linda Health Care System Director completes a review of mental health staffing and continues efforts to recruit and hire for Mental Health Service vacancies.
11. The Veterans Integrated Service Network 22 Director verifies that the Loma Linda VA Health Care System Director implements action items from previous external Veterans Health Administration site reviews.
12. The VA Loma Linda Health Care System Director makes certain that senior leaders consistently attend comprehensive environment of care monitoring rounds.
13. The VA Loma Linda Health Care System Director designates staff members to consistently enter data into the Comprehensive Environment of Care Assessment and Compliance Tool and

takes action, as necessary, to complete or address environment of care deficiencies to meet Environmental Program Service goals.

14. The Veterans Integrated Service Network 22 Director establishes a Veterans Integrated Service Network comprehensive environment of care policy and the VA Loma Linda Health Care System Director implements a facility level policy as required.

Appendix A: MHS Outpatient Access

Wait times for clinic appointments are a reflection of access. VHA captures data to determine the number of days until the third next available appointment for specific clinics and these data are used to measure access.⁹³ OIG staff utilized facility data to calculate the average wait times or access for five types of outpatient MHS services.

The OIG staff identified wait times for appointments with BHIP, providers as the main concern resulting from MHS staffing issues. The 2014 BHIP implementation guidelines presented a staffing model for BHIP teams with a target of 6.6-7.5 FTE per 1000 patients. Subsequent in 2015, VHA guidance identified a target of 7.72 FTE per 1000 patients for BHIP teams, noting that staffing to this ratio has been shown to be positively related to access.⁹⁴

Review of the BHIP teams staffing and panel sizes confirmed reports of understaffing on the Ambulatory Care Center BHIP teams. Using the staffing target of 7.72, five out of seven of the Ambulatory Care Center BHIP teams were staffed below the target. Using the lesser staffing target of 6.6, three out of seven Ambulatory Care Center BHIP teams were staffed below the target. Staffing for community based outpatient clinic (CBOC) BHIP teams met the 7.72 target.

The average wait times for a new patient intake appointment with a prescribing provider or therapy provider in BHIP, both at the Ambulatory Care Center and the CBOCs, exceeded the VHA 30-day timeliness standard.⁹⁵

Average wait times for established patient appointments with BHIP prescribing providers fell within the 30 day timeframe, with slightly higher wait times at CBOCs than at the Ambulatory Care Center. Average wait times for established patient appointments with BHIP therapy providers differed significantly between sites, with wait times at the CBOCs meeting the

⁹³ Third next available appointment refers to the average length of time in days between the day a patient makes a request for an appointment with a provider and the third next available appointment for the requested service (for example, a new patient evaluation or an established patient return visit). The third next available appointment is a commonly used measure of availability in health care settings. The third next available appointment is used rather than the next available appointment as a preferred measure for access, because it provides a more accurate estimation of true appointment availability. The next available appointment is more likely to be impacted by a cancellation or other unexpected event, whereas use of the third next available appointment removes the impact of such chance occurrences when measuring availability.

⁹⁴ Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Transition of Office of Mental Health Operations Funding and Mental Health Staffing Levels*, September 14, 2015.

⁹⁵ VA Loma Linda Health Care System has six associated CBOCs, including Blythe Rural Health Clinic, Corona VA Clinic, Murrieta, Palm Desert VA Clinic, Rancho Cucamonga VA Clinic, and Victorville VA Clinic, which offer primary care and mental health services. VHA policy on scheduling for outpatient services sets a timeliness goal for appointments to occur within 30 calendar days of the clinically indicated date specified by the provider or the date of the veteran request for an appointment. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

timeliness standard, while wait times at the Ambulatory Care Center exceeded the 30 day timeliness standard.

The average wait times for services through the BHIP, including the Evidence Based Therapy (EBT) Clinic are illustrated below (see Figure 1).

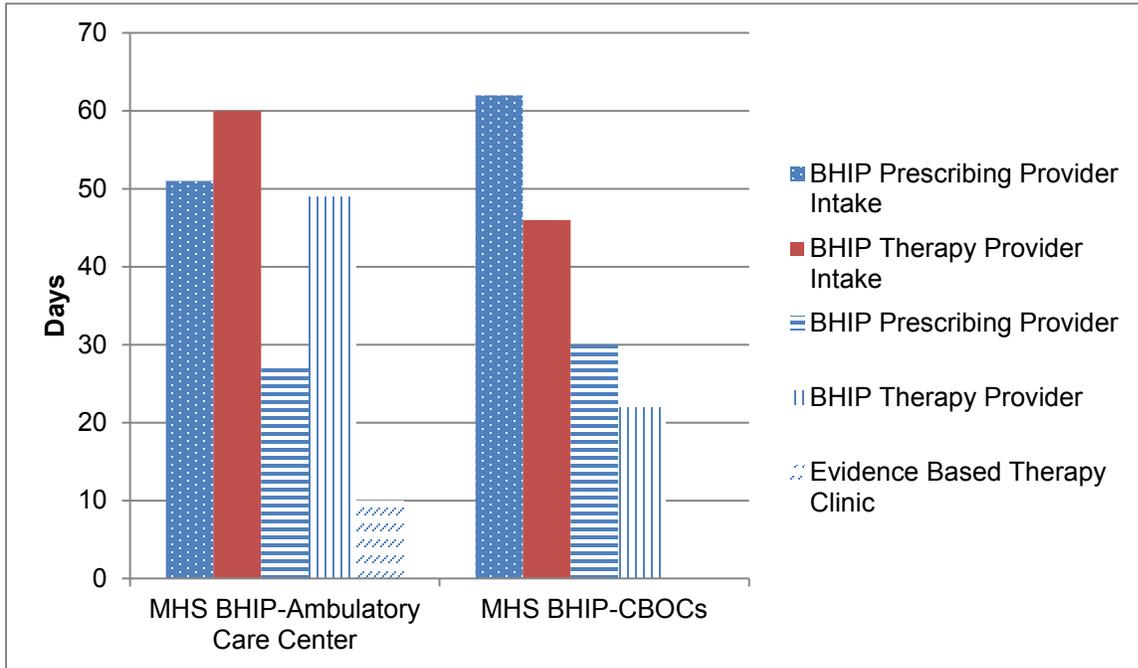


Figure 1. Average wait times for BHIP team appointments as of March 2018
 Source: VA OIG analysis of facility Clinic Access Summary data

In January 2018, leaders implemented EBT clinics, with protected appointment slots, for Ambulatory Care Center BHIP therapists.⁹⁶ The EBT slots were carved out of the BHIP therapists regular therapy clinics in order to create improved availability for the frequency of appointments necessary for time-limited EBT protocols. While this administrative allocation of provider time did not create new or increased supply, comparison of the wait times for the new EBT clinics and standard therapy clinics at the Ambulatory Care Center created greater appointment availability for episodes of care utilizing time-limited EBTs (see Figure 1).

MHS leaders used community based care referrals (Veterans Choice program) to address access problems and meet the need for mental health services, particularly therapy services, which could not be met with the facility’s MHS staffing. In FY 2017, the facility referred over 1,500

⁹⁶ Evidence-based psychotherapies are “specific psychological treatments that have been consistently shown in controlled clinical research to be effective for one or more mental or behavioral health conditions.” VHA Handbook 1160.05, *Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions*, October 5, 2012, revised December 8, 2015.

veterans for mental health care through the Veterans Choice program, more than triple the number referred in FYs 2016 or 2015. The Chief of MHS reported developing bundles for approval of medication management and psychotherapy services to be authorized for community based care to help monitor and standardize the facility’s use of the Veterans Choice program for mental health care.

Facility average wait times for services provided through the Primary Care Mental Health Integration (PCMHI),⁹⁷ Posttraumatic Stress Disorder (PTSD), Substance Use Disorder, and Suicide Prevention Programs are illustrated below (see Figure 2).

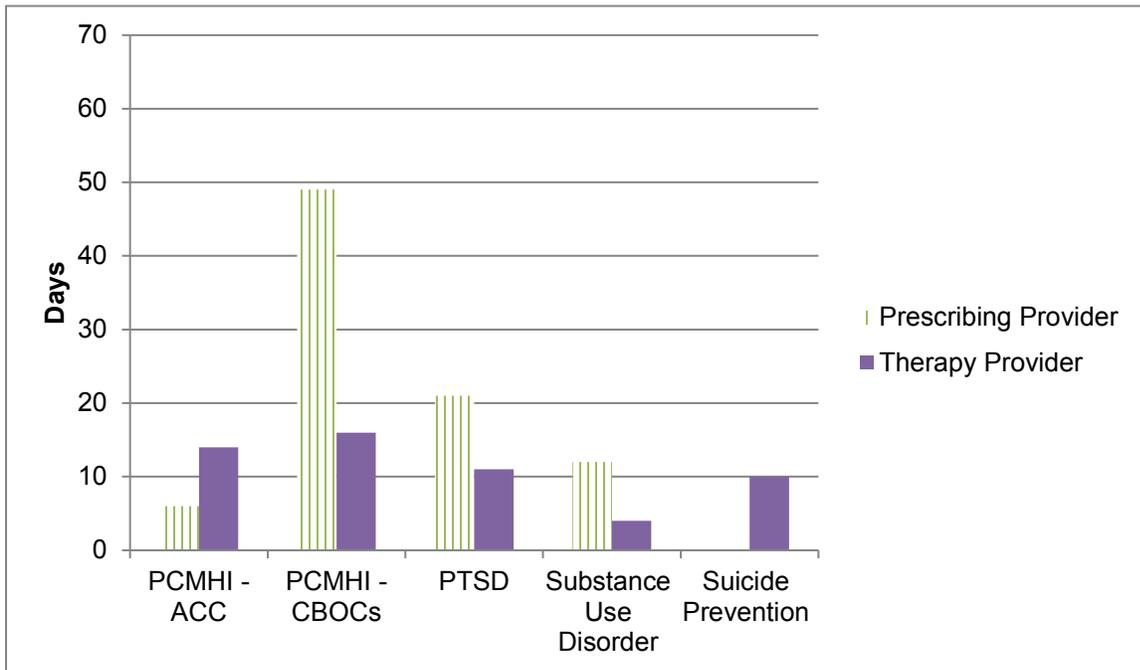


Figure 2. Average wait times for PCMHI, PTSD, Substance Use Disorder, and Suicide Prevention Programs Appointments as of March 2018

Source: VA OIG analysis of facility Clinic Access Summary data

PCMHI clinics met the timeliness standard with the exception of wait times for prescribing provider appointments at CBOC locations. The Chief of MHS identified telehealth use as a strategy

⁹⁷ PCMHI refers to mental health providers who are co-located and integrated into primary care teams to provide consultation, evaluation, and treatment for mild to moderate mental health conditions for patients whose mental health needs can be managed within the primary care setting.

for improving access for CBOCs lacking in prescribing provider staff resources.⁹⁸ Average wait times for mental health prescribing provider and therapy services in the specialty clinics for PTSD and Substance Use Disorders met the timeliness standard.

⁹⁸ Telehealth increases access to high quality health care services by using information and telecommunication technologies to provide health care services when the patient and practitioner are separated by geographical distance. *VA Telehealth Services Fact Sheet*, https://www.va.gov/COMMUNITYCARE/docs/news/VA_Telehealth_Services.pdf (The website was accessed on June 6, 2018.)

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 1, 2019

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership at the VA Loma Linda Healthcare System, Loma Linda, CA

To: Director, Office of Healthcare Inspections (54CH)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled Healthcare Inspection-Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership at the VA Loma Linda Healthcare System.
2. For any questions, feel free to contact me at (562) 826-5963. Thank you.

(Original signed by:)

Michael W. Fisher

VISN 22 Network Director

Comments to OIG's Report

Recommendation 11

Veterans Integrated Service Network 22 Director verifies that the Loma Linda VA Health Care System Director implements action items from previous external Veterans Health Administration site reviews.

Concur.

Target date for completion: July 30, 2019

Director Comments

The Veterans Integrated Service Network (VISN) 22 Director will verify that the Loma Linda VA Health Care System Director implements action items from previous external Veterans Health Administration site reviews.

Recommendation 14

Veterans Integrated Service Network 22 Director establishes a Veterans Integrated Service Network comprehensive environment of care policy and the VA Loma Linda Health Care System Director implements a facility level policy as required.

Concur.

Target date for completion: July 30, 2019

Director Comments

The Veterans Integrated Service Network (VISN) 22 Director will establish a VISN comprehensive Environment of Care Policy by May 30, 2019. The VISN will provide oversight of implementation of a facility level Environmental of Care Policy with verification of implementation by July 30, 2019.

Appendix C: System Director Comments

Department of Veterans Affairs Memorandum

Date: May 1, 2019

From: Director, VA Loma Linda HCS-Jerry L. Pettis Memorial Veterans' Hospital
(605/00)

Subj: Healthcare Inspection—Review of Environment of Care, Infection Control
Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System, CA

To: Director, Desert Pacific Healthcare Network (10N22)

1. Thank you for the opportunity to review and comment on the draft report, Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership at the VA Loma Linda Healthcare System.
2. I have reviewed and concur with the status of the actions and recommendations as submitted.
3. If you have any additional questions, please contact me at (909) 825-7084 ext. 6005.

(Original signed by:)

Karandeep S. Sraon

Medical Center Director

Comments to OIG's Report

Recommendation 1

VA Loma Linda Health Care System Director ensures implementation of system-wide comprehensive environment of care practices and a safe, sanitary, and high-quality environment consistent with Veterans Health Administration policy.

Concur.

Target date for completion: September 30, 2019

Director Comments

A site review from the VHA Director of Environmental Programs Service (EPS) was completed upon request to focus on the primary deficiencies observed from the March 8, 2018 OIG review. Upon completion of the EPS Site Review, Environmental Management Service (EMS) leadership is addressing each line item presented and improving processes for permanent solutions and compliance. The Assistant Director will monitor and track through the Environment of Care (EOC) Committee.

Recommendation 2

VA Loma Linda Health Care System Director makes certain that Environmental Management Service managers establish standard operating procedures and consistent processes for staff training.

Concur.

Target date for completion: SOPs Completed January 30, 2019

Staff Training documentation: June 28, 2019

Director Comments

Hospital Housekeeping Officer and Infection Control completed the review and approval of all Standard Operating Procedures (SOPs) on January 30, 2019. EMS staff utilizes approved SOPs for training of all staff assigned, to include: internal new employee orientation, service-level town hall meetings, and annual training for staff competencies.

Recommendation 3

VA Loma Linda Health Care System Director implements a standardized process and accountability for validating Environmental Management Service staff competencies.

Concur.

Target date for completion: June 28, 2019

Director Comments

EMS leadership is developing a comprehensive training for all staff. The trainings will include hands on practical demonstration and understanding will be managed through a competency checklist. Validation will be completed by direct observation, verbal or written response.

Recommendation 4

VA Loma Linda Health Care System Director verifies compliance with Veterans Health Administration policies for Sterile Processing Service controls.

Concur.

Target date for completion: June 28, 2019

Director Comments

Per inspection, deficiencies identified by OIG were immediately assessed by Sterile Processing Service (SPS) and addressed with training and monitoring. SPS staff have been trained to properly react and document air flow discrepancies within the department so that issues are addressed and repaired in a timely manner. A routine monitoring process for Biologicals is in place to prevent non-compliances in SPS documentation practices. The Associate Director for Patient Care Services will monitor the process and will be report to the Network SPS Advisory Board.

Recommendation 5

VA Loma Linda Health Care System Director complies with Veterans Health Administration policies developed to support Infection Prevention and Control Program issues identified in this report.

Concur.

Target date for completion: September 30, 2019

Director Comments

The facility will implement a supplemental reporting structure to address high priority complex multi-disciplinary conditions. This is to address infection control issues that are beyond the scope of any one service. A standing quarterly meeting with the ELB will be initiated to present these complex issues and how they are being rectified. Infection Control attends the daily senior management briefing to raise any issues or concerns requiring immediate intervention.

Recommendation 6

VA Loma Linda Health Care System Director ensures that hot water temperature systems are 124 degrees Fahrenheit or higher to inhibit *Legionella* growth.

Concur.

Target date for completion: June 28, 2019

Director Comments

The facility will implement a routine hot water loop temperature monitoring program and reporting to the facility Water Safety Committee monthly.

Recommendation 7

VA Loma Linda Healthcare System Chief of Staff and Associate Director of Patient Care Services implements a standardized process, consistent with Veterans Health Administration policy, to notify clinical staff involved in direct patient care when routine environmental water testing is positive for *Legionella* to increase diagnostic awareness.

Concur.

Target date for completion: On going

Director Comments

The Water Safety Committee notifies employees regarding the testing results of *Legionella* and on-going mitigation, including clinical staff. In addition, information is communicated to Service Chiefs during staff meetings.

Recommendation 8

VA Loma Linda Health Care System Director continues to recruit and hire for hospitalist vacancies.

Concur.

Target date for completion: September 30, 2019

Director Comments

Medical Service had 4 Hospitalist vacancies and selections have been made for all positions and applicants are processing through HR.

Recommendation 9

VA Loma Linda Health Care System Director monitors action plans for the Mental Health Strategic Analytics for Improvement and Learning measures.

Concur.

Target date for completion: September 30, 2019

Director Comments

The Director will establish a Behavioral Health Steering Committee focused on measuring system performance in the delivery of comprehensive mental health care access, quality, and experience of care. The Mental Health (MH) Service Chief and key MH SAIL leaders will meet monthly with the Director to discuss and monitor the MH actions for improvement.

Recommendation 10

VA Loma Linda Health Care System Director completes a review of mental health staffing and continues efforts to recruit and hire for Mental Health Service vacancies.

Concur.

Target date for completion: Ongoing

Director Comments

The Executive Resource Board reviews all submitted vacancies for Mental Health recruitment consideration.

Recommendation 12

VA Loma Linda Health Care System Director makes certain that senior leaders consistently attend comprehensive environment of care monitoring rounds.

Concur.

Target date for completion: Completed

Director Comments

Environment of care (EOC) Senior Leadership attendance is tracked by the weekly attendance sheets of EOC rounds which are reported to the EOC committee monthly.

Recommendation 13

The VA Loma Linda Health Care System Director designates staff members to consistently enter data into the Comprehensive Environment of Care Assessment and Compliance Tool and takes

action, as necessary, to complete or address environment of care deficiencies to meet Environmental Program Service goals.

Concur.

Target date for completion: Completed

Director Comments

The Safety Service was given an additional FTE for the data management for the EOC Reporting Tool (Performance Logic System) and is used to track all findings, with the goal of correcting those findings within 14 days. Any possible deficiencies that may require longer periods for correction are corrected through the facility work order system and closed as appropriate. The EOC Board maintains these items as Action Items and are tracked until closure. Any items that go beyond their assigned due dates are sent to Executive Leadership for immediate response and resolution.

Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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